STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner
v **File No. 89382-001**

Physicians Health Plan of Mid-Michigan
Respondent
_____/

Issued and entered
This 3rd day of July 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 24, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On April 30, 2008, the Commissioner accepted the request.

The issue in this external review can be decided by a contractual analysis. The contract here is the certificate of coverage issued by Physicians Health Plan of Mid-Michigan (PHPMM). The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner is a member of PHPMM. His health care benefits are defined in the certificate. The certificate provides for both network and non-network benefits. To obtain network benefits, treatment must be provided by an in-network provider. Care from non-network providers may be covered but generally comes with a higher out-of-pocket cost for the PHP member. The

certificate permits in-network-level benefits for out-of-network services when the services are not available from network providers or for emergency care.

The Petitioner was diagnosed with an adenoma of the prostate which required that a prostatectomy be performed. After consulting with his physician and researching his options, Petitioner requested authorization for his surgery to be performed at XXXXX by Dr. XXXXX. PHPMM denied coverage at the in-network reimbursement level but approved coverage at the non-network level, which required the Petitioner to pay a $200.00 deductible with PHPMM paying 80% of eligible expenses. The Petitioner appealed but PHPMM affirmed its original decision. Petitioner had the surgery performed at XXXXX on February 7, 2008 while his claim review was pending.

The Petitioner exhausted PHPMM's internal grievance process and received its final adverse determination dated February 25, 2008.

III
ISSUE

Did PHPMM properly deny coverage for the Petitioner's services at the in-network level?

IV
ANALYSIS

Petitioner's Argument

The Petitioner disagreed with PHPMM's decision saying that while the services in question may be available within the PHPMM network, the services "are not comprehensive nor do they give the same levels of assurance to safeguard against negative side effects."

Petitioner says his primary care physician, Dr. XXXXX, and network physicians encouraged his choice to have treatment at XXXXX. In a letter dated January 22, 2008, Dr. XXXXX wrote:

> Mr. XXXXX has been diagnosed with Adenocarcinoma of the Prostate. He has consulted with urologists and researched his options. He has elected to proceed with prostate surgery (laparoscopic/robotic). The patient has researched this procedure and apparently found that approximately 300 of these procedures have been done in XXXXX in the past two years with 14 done in the last year by his local urologist Dr. XXXXX. Apparently XXXXX has performed approximately 3800 of these procedures in the past 7 years with approximately 2800 of these being done by Dr. XXXXX whom he has

> consulted with and wishes to perform the procedure. Mr. XXXXX has put a great deal of thought and research into the decision regarding his treatment and feels this course gives him the best experience in surgeons and is in his best interest for a successful outcome. I support his decision and his reasoning for pursuing this path of treatment and would hope that PHP as his insurance provider would also support this decision and see that this may be in the best interest of this patient and consider approving coverage for this care.

Petitioner says that he was advised on more than one occasion that XXXXX and Dr. XXXXX were part of the PHP network. He also argues that, although other in-network hospitals may have a machine to perform the surgery, they agree their physicians do not possess the level of knowledge and training as Dr. XXXXX. Finally, he could not find any documentation that Lansing-area urologists have demonstrated the skills to perform the same procedure that Dr. XXXXX performs. Petitioner therefore had the surgery at XXXXX and believes PHPMM should cover the services at the network level due to the expertise of Dr. XXXXX and XXXXX.

Respondent's Argument

PHPMM's final adverse determination of February 25, 2008 states:

> The original decision to deny your request was upheld because the services are available within the PHPMM network, including XXXXX. Henry Ford Hospital's participation status with PHPMM is an out of network agreement which means services that are preauthorized are covered there if the services are not available within the PHPMM network of providers. Because their participation status is an out of network agreement they do not appear as a participating provider in PHPMM's Provider Directory.

In support of its ruling, PHPMM cites these provisions in the certificate of coverage:

> **Section 1: What's Covered – Benefits**
> **Accessing Benefits**
>
> You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits, Covered Health Services must be provided by a Network Physician or other Network provider in the Physician's office or at a Network facility. For facility services, Network Benefits apply to Covered Health Services that are provided at a Network facility by or under the direction of either a Network or non-Network Physician or other provider. For details about when Network Benefits apply, see Section 3: Description of Network and Non-Network Benefits.
>
> **SECTION 3: Description of Network and Non-Network Benefits**

> **Network Benefits**
> - Network Benefits are generally paid at a higher level than Non-Network Benefits.
>
> * * *
>
> ***Health Services from Non-Network Providers Paid as Network Benefits***
> If we determine that specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us, and we will work with you and your Network Physician to coordinate care through a non-Network provider. You are responsible for verifying that we have approved the request. If you see a non-Network provider without verifying in advance that we have approved your visit, Network Benefits will not be paid. Non-Network Benefits may be available if the services you receive are Covered Health Services for which Benefits are provided under the Policy.

PHPMM says the services the Petitioner needed were available within its network. Based on the language in the certificate, PHPMM believes that the services from Dr. XXXXX and XXXXX were appropriately covered at the non-network level.

Commissioner's Review

The Petitioner has asserted that XXXXX and Dr. XXXXX are participating providers and, for that reason, coverage should be provided at the in-network level. It is correct that these providers do participate with PHPMM. However, that is not the same as being an in-network provider. These providers are not part of the PHPMM network and their services, therefore, are not subject to the more financially favorable terms of coverage.

It is also the Petitioner's contention that the services he received at XXXXX and from Dr. XXXXX were not available within PHPMM's network. However, PHPMM has identified two hospitals in its network where the procedure is performed, and there is nothing in the record from which the Commissioner could conclude that the Petitioner could not or should not have received services from either of those two facilities.

PHPMM approved coverage at the out-of-network level for Petitioner's surgery, applying the deductible and then paying 80% of eligible expenses. The Petitioner argues that coverage should be at the in-network level because the out-of-network surgeon, Dr. XXXXX, had greater expertise to

perform the surgery than in-network providers. Even granting that Dr. XXXXX has greater experience or expertise than in-network providers in performing the procedure in question, it remains true that in-network providers were available. Comparative experience is not a factor in determining whether in-network benefits are available. Since the record here does not establish that PHPMM's network oncology providers were not able to provide medically necessary services for the Petitioner, the Commissioner finds that PHPMM's determination of benefits was appropriate. PHPMM is not required to provide network level coverage for the Petitioner's services from out-of-network providers.

V
ORDER

The Commissioner upholds PHPMM's final adverse determination of February 25, 2008.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.